TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL COMPOUNDING RX

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-19-2516

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 10, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have attached the EOB's as well as the documentation to prove that Memorial Compounding Pharmacy has met the requirements to receive reimbursement."

Amount in Dispute: $1,304.22

RESPONDENT'S POSITION SUMMARY

Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 29, 2018	Pharmaceutical Compound	$702.68	$0.00
January 29, 2018	Gabapentin 300 mg Capsules	$178.26	$0.00
January 29, 2018	Cyclobenzaprine 10 mg Tablets	$155.78	$0.00
January 29, 2018	Lenzapatch 4%-1%	$267.50	$0.00
	Total	$1,304.22	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

- B11 – The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
- 109 – Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did New Hampshire Insurance Company respond to the medical fee dispute?
2. Is Memorial Compounding Rx entitled to reimbursement?

Findings

1. The Austin carrier representative for New Hampshire Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on January 17, 2019. If the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.[1]

   As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Memorial Compounding Rx is seeking reimbursement for drugs dispensed on January 29, 2018. Explanations of benefits from Gallagher Bassett denied liability for reimbursement, in part, stating, "Claim not covered by this payer/contractor."

   DWC reviewed available information. No evidence was presented to support that the bills in question were submitted to New Hampshire Insurance Co or its agent. The DWC concludes that Gallagher Bassett's denial is supported. Therefore, no reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		August 24, 2021
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §133.307(d)(1)

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.